SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Lincoln Heritage Life Insurance Company

Product Name: Medicare Supplement 2009 Outline of Coverage	SERFF Tr Num: LHLI-125839345	State: ArkansasLH
TOI: MS06 Medicare Supplement - Other	SERFF Status: Closed	State Tr Num: 40405
Sub-TOI: MS06.000 Medicare Supplement - Other	Co Tr Num: MS-OCAR 09 CP	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Stephanie Fowler
	Authors: Cathy Patterson, Wanda McNeece, Sally Roudebush, Rodney Hartwig	Disposition Date: 10/29/2008
	Date Submitted: 09/30/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Illinois does not require yearly filing of outlines of coverage for Medicare Supplement.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/29/2008	
State Status Changed: 10/29/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

see cover letter

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Cathy Patterson,
4343 E Camelback Rd
Phoenix, AZ 85018

cathy.patterson@londen-insurance.com
(800) 433-8181 [Phone]
(602) 808-8845[FAX]

Filing Company Information

Lincoln Heritage Life Insurance Company
4343 East Camelback Road
Phoenix, AZ 85018
(800) 433-8181 ext. [Phone]

CoCode: 65927
Group Code:
Group Name:
FEIN Number: 04-2314290

State of Domicile: Illinois
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	1 form X $50.00 = $50.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Heritage Life Insurance Company	$50.00	09/30/2008	22836569

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	10/29/2008	10/29/2008

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/29/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	Yes
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	Yes
Form	Medicare Supplement 2009 Outline of Coverage	Approved	Yes

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: MS-OCAR 09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	MS-OCAR 09	Outline of Coverage	Medicare Supplement 2009 Outline of Coverage	Initial		41	MS-OCAR for 2009.pdf

LINCOLN HERITAGE LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, C, D and F

These charts show the benefits included in each Medicare supplement plan. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year {$2,000} deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are {$2,000.} Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.

LINCOLN HERITAGE LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	{$4,620} Out of Pocket Annual Limit ***	{$2,310} Out of Pocket Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**
See Outlines of Coverage for details and exceptions.

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

SEMI-ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

QUARTERLY PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

MONTHLY PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

PREMIUM INFORMATION

Lincoln Heritage Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as underwriting class, state and zip code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Administrative Office at 4343 East Camelback Road, Phoenix, Arizona 85018. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Lincoln Heritage Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	$0	{$1,068} (Part A Deductible)
61st - 90th day	All but{$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:		100% of Medicare	
- Additional 365 days	$0	Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	$0	Up to {$133.50} a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	$0	Up to {$133.50} a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 {$135} (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD First 3 pints Next {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 {$135}(Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 {$135}(Part B Deductible) $0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	($534} a day	$0
- Once lifetime reserve days are used:		100% of Medicare Eligible	
- Additional 365 days	$0	Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN D PAYS**	**YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 {$135}(Part B Deductible) $0
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	$0 $0 $0	Actual charges to {$40} a visit Up to the number of Medicare Approved visits, not to exceed 7 each week. {$1,600}	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000.	$250 20% and amounts over the $50,000 lifetime maximum

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	{$135}(Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LHLI-125839345*	*State:*	*Arkansas*
Filing Company:	*Lincoln Heritage Life Insurance Company*	*State Tracking Number:*	*40405*
Company Tracking Number:	*MS-OCAR 09 CP*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement 2009 Outline of Coverage*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 09/30/2008

Comments:
flesch score certification attached.

Attachment:
CERT OF FLESCH.pdf

Review Status:

Bypassed -Name: Application 09/30/2008

Bypass Reason: n/a, not filing a policy.

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification Accepted for Informational Purposes 10/29/2008

Bypass Reason: n/a, not filing a policy.

Comments:

Review Status:

Satisfied -Name: Outline of Coverage Accepted for Informational Purposes 10/29/2008

Comments:
outline of coverage attached.

Attachment:
MS-OCAR for 2009.pdf

CERTIFICATION OF FLESCH READABILITY SCORE

Arkansas

I certify that the forms listed below achieve the following:

(1) The text achieves a minimum score of 41 on the Flesch reading ease test.
(2) Except for specification pages, schedules, and tables the forms are printed in not less than ten (10) point type, one (1) point leaded.

Policy Form(s): MS-OCAR 09 - Medicare Supplement Outline of Coverage

LINCOLN HERITAGE LIFE INSURANCE COMPANY

Cathy Patterson, Senior Compliance Associate

September 30, 2008

LINCOLN HERITAGE LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, C, D and F

These charts show the benefits included in each Medicare supplement plan. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year {$2,000} deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are {$2,000.} Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.

LINCOLN HERITAGE LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	{$4,620} Out of Pocket Annual Limit ***	{$2,310} Out of Pocket Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**
See Outlines of Coverage for details and exceptions.

LINCOLN HERITAGE LIFE INSURANCE COMPANY

ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

SEMI-ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

QUARTERLY PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

LINCOLN HERITAGE LIFE INSURANCE COMPANY

MONTHLY PREMIUM RATES
FOR USE IN ARKANSAS

Ages 65-99	Plan A	Plan B	Plan C	Plan D	Plan F
Preferred Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, and all zip codes beginning with 722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for Zip Codes beginning with 720 and 721 not listed above	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Preferred Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**
Standard Rates for all Zip Codes except 720-722	**{XXX}**	**{XXX}**	**{XXX}**	**{XXX}**	**XXX}**

PREMIUM INFORMATION

Lincoln Heritage Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as underwriting class, state and zip code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Administrative Office at 4343 East Camelback Road, Phoenix, Arizona 85018. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Lincoln Heritage Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	$0	{$1,068} (Part A Deductible)
61st - 90th day	All but{$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:		100% of Medicare	
- Additional 365 days	$0	Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	$0	Up to {$133.50} a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	$0	Up to {$133.50} a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 {$135} (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD First 3 pints Next {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 {$135}(Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 {$135}(Part B Deductible) $0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	($534} a day	$0
- Once lifetime reserve days are used:		100% of Medicare Eligible	
- Additional 365 days	$0	Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	$0	{$135}(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES –TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN D PAYS**	**YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First {$135} of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 {$135}(Part B Deductible) $0
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	$0 $0 $0	Actual charges to {$40} a visit Up to the number of Medicare Approved visits, not to exceed 7 each week. {$1,600}	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000.	$250 20% and amounts over the $50,000 lifetime maximum

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but {$1,068}	{$1,068}(Part A Deductible)	$0
61st - 90th day	All but {$267} a day	{$267} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but {$534} a day	{$534} a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but {$133.50} a day	Up to {$133.50} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed {$135} of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First {$135} of Medicare Approved Amounts*	$0	{$135}(Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First {$135} of Medicare Approved Amounts*	$0	{$135} (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum